NOW HEALTH INTERNATIONAL

Intermediary application form

Please complete this form in BLOCK CAPITALS.

Please send your completed application form to Now Health International Limited, PO Box 482055, Dubai, UAE.

You can also scan and email it to MEAQuotes@now-health.com or fax it to +971 (0) 4450 1530.

Section 1: Intermediary details

1.1	Full legal name of intermediary:
1.2	Trading name(s) if applicable:
1.3	Place of registration:
1.4	Business registration number (a copy of registration certificate is required):
1.5	Date of registration (dd/mm/yyyy): / /
1.6	Incorporating Body:
1.7	Incorporation number:
1.8	Incorporation date:
1.9	Registered address:
1.10	Trading address (if different from 1.9):
1.11	Legal form of your firm (e.g. Limited Liability Company):
1.12	Countries where you operate/generate revenue? (if additional to the above):
1.13	Website address:
1.14	Names of all Registered Directors:
1.15	Name(s) of the Ultimate Beneficial Owner(s) (natural persons owning more than 5%):
1.16	Is the Intermediary, any party connected to the Intermediary or any employees, their family members or close associates, a politically exposed person? Yes ☐ No ☐
1.17	Is your firm owned, in whole or in part, by another organisation? Yes ☐ No ☐

If yes, please state the name(s) and registration and incorporation jurisdiction(s) of the organization(s) together with the percentage of ownership and the type of business carried on by it (or each of them) and whether it is DFSA regulated. Please provide a copy of the company structure chart (if applicable) and registration certificate of each one of these organisations.

1.18 Details of shareholders:
Please state the full name(s) of the firm's shareholders/partners holding more than 25% of issued capital together with their nationality, date of birth and the percentage of their corresponding ownership. If a shareholder owns the controlling stake, in the case of a company please provide details of the ultimate owner.

Name	Nationality	Date of birth (dd/mm/yyyy)	Shareholding Percentage
		/ /	
		/ /	
		/ /	

1.19 Details of Board members:
Please provide the full name(s), nationality, date of birth and current domicile of all Board Members.

Name	Nationality	Date of birth (dd/mm/yyyy)	Address	Shareholding Percentage
		/ /		
		/ /		
		/ /		

Section 2: Intermediary relationship holder details

2.1 Responsible person for application:

First name(s): | Family name:

What do you like to be called?

(If your full name is John Andrew Smith, you might like to be called John or Mr Smith or Andy. We will address all correspondence to you in this way.)

2.2 Telephone: | 2.3 Fax:

2.4 Email:

Section 3: Intermediary contact details

3.1 Contact person for future business operation (if different from Section 2)

First name(s): | Family name:

What do you like to be called?

(If your full name is John Andrew Smith, you might like to be called John or Mr Smith or Andy. We will address all correspondence to you in this way.)

3.2 Telephone: | 3.3 Fax:

3.4 Email:

Section 4: Authorisations

4.1 Name of body and country that regulates your insurance intermediary activity (a copy of current authorisation required):

4.2 Date of authorisation (dd/mm/yyyy): / /

4.3 Number of your firm's licensing/registration by the regulator:

4.4 Has your firm or any of its staff been subject to disciplinary action or investigation by regulators? If yes, please provide details: Yes ☐ No ☐

4.5 GIIN Number (if firm is FACTA registered):

4.6 Has the firm, directors or senior managers been convicted of any criminal offence? If yes, please provide details: Yes ☐ No ☐

4.7 Has the firm, directors or senior managers been subject to insolvency or bankruptcy proceedings or come to any agreement with creditors over unpaid debts? If yes, please provide details: Yes ☐ No ☐

4.8 Does your firm have arrangements in place to prevent bribery and corruption, money laundering and breaches of sanctions policies? If yes, please provide details: Yes ☐ No ☐

4.9 Has your firm had any previous record of, or does it anticipate any infringement of bribery and corruption, money laundering and breaches of sanction policies? If yes, please provide details: Yes ☐ No ☐

4.10 What is the scope of your authorisation and/or your authorised business line(s)? Please provide details:

4.11 What is the geographic limitation of your authorisation? Please provide details:

4.12 Do you have a valid professional indemnity policy to cover your activity? (A copy of your current policy schedule is required.) Yes ☐ No ☐

4.13 Please provide the names, qualifications and experience of your senior executives:

4.14 Has your firm ever had any agencies with an insurance company refused or cancelled? If yes, please give details: Yes ☐ No ☐

4.15 Is your firm registered with a data protection agency?
Please provide your registration number and details of how this can be checked: Yes ☐ No ☐

Section 5: Industry experience

5.1 What is your experience in health insurance? Please provide details:

5.2 What is your average gross premium written in health insurance during the last 24 months?

5.3 Please provide the contact details of two major suppliers for us to take references:

5.4 Bank details for commission/brokerage payments:

Section 6: Required Documentation

Please provide copies of the valid documents as listed below along with this signed form. These documents must be in **English** or accompanied by a translation into English:

- **This completed application form (signed & stamped)**
- **Certificate of Incorporation / Registration**
- **Valid Commercial License / Trade License**
- **Regulatory License (if applicable)**
- **Articles of Association / Memorandum of Association**
- **Professional Indemnity Insurance certificate (for Intermediaries / Brokers ONLY)**

Section 7: Important notes

Data Protection

Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

We and the Underwriters will deal with all personal information supplied in the strictest confidence as required by the Personal Data Protection Act. **We** and **Your** underwriters collect personal information about **You** and **Your Dependents** (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administrating **Your Plan**, Underwriters, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside **Your** country of residence. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the country of **Your** residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organizations without **Your** consent.

You have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the **Plan**, including claims correspondence, will be sent to the Planholder. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practice may be impaired.

Please contact **Our** Customer Services team or write to us at the address on the back of this form if **You** wish Now Health International group companies to contact **You** via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com/privacy

Your health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

Sanctions Limitation and Exclusion

We will not provide cover nor pay claims under this **Plan** if **Our** obligations (or the obligations of **Our** group companies & administrators) under the laws of any relevant jurisdiction including UAE, UK, European Union, the United States of America, United Nations resolutions, trade or economic or international laws sanctions, prevents or restricts **Us** from doing so.

We will not provide You with any services or Benefits including but not limited to acceptance of premium payments, claim payments and other reimbursements if in doing so, **We** violate applicable law, regulation, code or court order or are or will be otherwise sanctioned, prevented or restricted.

We may terminate Your Plan if **We** consider **You** or **Your** directors or officers as sanctioned persons, or **You** conduct an activity which is sanctioned, according to trade or economic laws & regulations.

Important note: We regard the rights above as best practice but the legal requirements may differ in the country in which You reside. Please contact Us for additional information regarding regulations in Your jurisdiction.

By signing this Application Form **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

Section 8: Declaration

We declare that answers and statements given in this application are accurate to the best of our knowledge and undertake to inform Now Health International Limited of any material change of circumstances promptly.

We further declare that we have the necessary licence and authorisation to carry and advise plans managed by Now Health International Limited in the market we operate.

Signature:	**Date** (dd/mm/yyyy):
	/ /

Official stamp:

Now Health International Limited ("NHIL"), which is regulated by
the Dubai Financial Service Authority, issues plans underwritten by Best Doctors Insurance Limited
(which is regulated by the Bermuda Monetary Authority and is under the same common ownership as NHIL)

Plans are only available to those outside the UAE.

Now Health International Limited - Registered Office: Office 814, Liberty House, Level 8, Gate Drive Street, P.O.Box 482055, Dubai.

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